CENTRAL DISTRICT HEALTH DEPARTMENT

To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.

MAIN OFFICE *707 N Armstrong Place, Boise, ID 83704-0825 (208) 327-7450 Fax (208) 327-8580

CLIENT INFORMATION FORM

Name (Last) _____ **First** _____ **Middle**_____

Date of Birth _____/_____/_____ **Age** _____

Mailing Address _____

City _____**State**_____ **Zip**_____

Residence Address _____
(If different from mailing address)

Gender Female / Male **Language** English / Spanish Other _____
SS# (optional) _____

Home Phone _____**Work Phone** _____ **Msg Phone** _____

Parent or Guardian _____ **Mother's Maiden Name**_____

OPTIONAL
Ethnicity Hispanic / Not Hispanic / Unknown

Race White / American Indian / Black / Alaskan Native / Asian / Hawaiian – Pac Islander / Other

Circle all that apply *Ages 0-18 yrs only*
Medicaid / No Insurance / Insurance / Native American / Alaskan Native

At birth were you a
Single / Twin / Triplet / Other

Is today's service covered by a voucher?
____ yes ____ no

Is Patient on the **WIC** program?
____ yes ____ no

FINANCIAL POLICY: Effective September 8, 2008

INSURANCE: We no longer bill insurance for immunization services. Payment is expected at time of service. If you wish to bill your insurance company, please ask for information at check-out.

MEDICAID: Please present your Medicaid card at check-in. Non-covered services will be your responsibility.

MEDICARE: We are not a Medicare provider. Payment is expected at time of service. We will send your bill to Medicare, but only **FLU** and **PNEUMONIA** will likely be covered. Other services will probably not be reimbursed by Medicare. Questions about your coverage should be directed to Medicare.

No childhood immunizations will be denied due to inability to pay. Please ask for information at check-in.

ALL CLIENTS PLEASE READ THE FOLLOWING AND INITIAL

_____ I hereby acknowledge that I was given a copy and I have read or had explained to me the Central District Health Department Notice of Privacy Practices.

_____ I have read and understand the Financial Policy.

IRIS: I give permission to enroll me or my child and to transfer my or my child's immunization records into the Idaho Immunizations Reminder Information System (IRIS) to ensure that this vaccination record is available to me, my or my child's health care providers and schools. I understand I may be asked for information that will help ensure my or my child's records are accurate and will not be confused with another person's records, such as: mother's maiden name, telephone number, child's gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS.

_____ NO (do not enroll me/my child in IRIS)

Signature of person receiving vaccine or the person authorized to make the request:

SIGNATURE X_____ DATE _____

********FOR OFFICE USE ONLY********

_____ _____ _____

_____ _____ _____

CENTRAL DISTRICT HEALTH DEPARTMENT

To improve the health of our communities by identifying sustainable solutions to community health issues, developing partnerships for implementation of strategies, and demonstrating our success through measurement of outcomes.
MAIN OFFICE *707 N Armstrong Place, Boise, ID 83704-0825 (208) 327-7450 Fax (208) 327-8580

Medical History

The following questions will help us determine which vaccines you may be given today. If a questions is not clear, please ask a health care provider to explain it. ***PLEASE CIRCLE ANSWER***

Is the patient sick today?	YES	NO	NOT SURE
Does the patient have allergies to medications, food, or any vaccine?	YES	NO	NOT SURE
Has the patient ever had a serious reaction after receiving a vaccination?	YES	NO	NOT SURE
Has the patient had a seizure or brain problem?	YES	NO	NOT SURE
Does the patient have cancer, leukemia, HIV/AIDS, or any other immune system problem?	YES	NO	NOT SURE
Does the patient take cortisone, prednisone, other steroids, or anti-cancer drugs, or has the patient had x-ray treatments?	YES	NO	NOT SURE
During the past year, has the patient received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	YES	NO	NOT SURE
Has the patient received any vaccination in the past 4 weeks?	YES	NO	NOT SURE
Has the patient had chickenpox?	YES	NO	NOT SURE
For women: Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO	NOT SURE

According to Idaho Statute 39-4804, IMMUNIZATION NOTIFICATION TO PARENT OR GUARDIAN, before an immunization is administered to any child in this state, the parent or guardian of the child should be notified that: (1) Immunizations are not mandatory and may be refused on religious or other grounds; (2) Participation in the immunization registry is voluntary; (3) The parent or guardian is entitled to an accurate explanation of the complications known to follow such immunization.

Signature of person completing form:_____ **Date:**_____ **Nurse:**_____

(DO NOT MARK BELOW THIS LINE)

I have reviewed the information above and made changes if indicated.

Date: _____ Client/Guardian initials: _____ Nurse initials: _____
Date: _____ Client/Guardian initials: _____ Nurse initials: _____
Date: _____ Client/Guardian initials: _____ Nurse initials: _____
Date: _____ Client/Guardian initials: _____ Nurse initials: _____
Date: _____ Client/Guardian initials: _____ Nurse initials: _____

Client Name/DOB Label